Health Action Plan Instructions

The Health Action Plan (HAP) is a tool to document goals that the member will pursue within the Health Home. The HAP also documents the proposed process for achieving these goals, as well as progress. The HAP is developed by the member and Care Manager or Coordinator, with input from others who are participating in the Health Home, and anyone else the member chooses to include in the process.

Sections I through III

Sections I, II, and III of the HAP are provided to document demographic, contact, and physical and behavioral health information. Drop down boxes are provided for some information, while other information must be typed in. Not all information requested will apply to each member. When information does not apply, type in N/A.

Section IV

Indicate whether the member has a Home and Community Based Services waiver plan in place, and the type of waiver plan.

Section V

Indicate whether the member has an Advanced Directive, and where it is located.

Section VI

Health Home goals are documented in Section VI. Members may have as few as one Health Home goal, or they may have several. Documentation in Section VI should include the following:

- **Goal:** The goal should be something that will contribute to improving the member's health and well-being.
    - Earleen will choose one Primary Care Physician (PCP) to oversee her medical care.
- **Steps to Achieve Goal:** Address the steps that will be taken to achieve the goal, including who is responsible to assist the member in achieving the goal and where services will be provided.
    - Earleen's Care Coordinator will
        - assist her to choose a PCP and schedule her first appointment
        - attend the first appointment with Earleen to help her explain her medical issues, her participation in a Medicaid Health Home, and help her to understand the information provided by the PCP
        - educate Earleen regarding how to set up transportation through her MCO for future appointments

- **Strengths and Needs:** This section should address any strengths that may help the participant to achieve the goal, or needs that may prove a barrier to achieving the goal. Consideration should be given to such areas as family or community support, communication, education, socio-economic status, housing, transportation, etc.
    - Earleen has a sister with whom she currently lives, however she is unable to provide much support in terms of Earleen's physical or behavioral care, including transporting her to and from appointments. Earleen will need transportation, and will need someone to go with her to her initial visit, at a minimum.
- **Measureable Outcome(s):** This section should state how it will be determined that this goal was met.
    - Earleen will select a PCP, schedule and attend an initial appointment. She will continue to see her PCP on a schedule recommended by her PCP.
- **Start Date:** Indicate the date the goal is established. **Completion Date:** Indicate the date the goal was met.
- **Progress:** Document any progress toward achieving the goal.
    - Earleen selected a PCP from a list provided by her Care Coordinator. With the assistance of her Care Coordinator, she scheduled her first appointment for 02/11/14 at 1:30 PM. Her Care Coordinator will take her to her initial appointment.

Section VII

Section VII includes the signature of the participant, as well as the signatures of those who participated in developing the HAP and their relationship to the participant. Copies should be given to the participant, those who participated, as well as anyone else involved in achieving the goal(s) established in the HAP.